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CLINICAL LECTURES.

ON URETHRAL STRICTURE.

A Clinical Lecture delivered at the Jefferson College Hospital.

By JOHN H. BRINTON, M.D.,
Surgeon to the Jefferson College Hospital.

GENTLEMEN: During the last three or four weeks I have brought before you a number of exceedingly interesting cases of urethral stricture, and it seems to me that we may now, with profit, pause and pass in review the phenomena characterizing this affection, and the various procedures adopted for its treatment.

As you are aware, the chief symptom of stricture is an inability or difficulty, to

a greater or less extent, in passing water. I say the chief symptom, for, in truth, many other phenomena cluster around this one evidence of disease. Of these, however, the patient may be, and probably is, ignorant; his mind is fixed on the one great fact, that urination is with him a source of anxiety, oftentimes accompanied by distress and pain. He will come to you for relief, and upon your just appreciation of his trouble, and upon the adroitness of your hands, must his welfare depend.

Inability to urinate may depend upon stricture of the urethra and its consequences, or upon affections of the prostate gland or bladder. But it is only with stricture and its results that we are occupied this morning. Stricture is ordi-

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narly divided into the inflammatory, spasmodic, and organic varieties. Of the first two I shall not now speak, but shall confine myself entirely to organic stricture, or stricture as it is usually called. The essential element of organic stricture is an inability on the part of the urethral mucous membrane to be dilated to its normal extent or calibre. In the healthy condition of the canal the mucous lining falls into folds, its surfaces resting in contact; by the passage of an instrument, or upon the flow of the urine, these surfaces are separated, and the calibre of the canal is thus increased or dilated. But when from any inflammatory cause, such as urethritis and gleet, chronic changes and deposits are developed in the mucous or submucous tissues, forbidding the dilation or opening out of the canal, organic stricture is established. One of the first effects of the chronic inflammation, inseparable from gleet, is the early occurrence, at different portions of the urethral tract, of granular conditions. The mucous surface at these points loses its normal smooth appearance and becomes studded with minute granulations analogous to those observed on the eyelids in granular conjunctivitis.

This is the condition described by Desormeaux as granular urethritis, and it is one which I have frequently been able to study with the endoscope. It is more than likely that during this period those changes are set up which eventually develop into stricture. When the protecting epithelial layer of the mucous surface is lost, the irritating urine can act directly upon the walls of the canal, and, as a natural result, the formation of plastic lymph ensues. If this be not absorbed, but increase in quantity so as to involve the entire thickness of the mucous layer, or the submucous tissues as well, stricture would appear to be inevitable. Unfortunately, it would seem that when this mischievous lymph is once poured out, there is often but little tendency to its absorption. On the contrary, its disposition appears to be rather to harden and contract, thus insuring the establishment and continuance of the stricture. Occasionally, the lymph deposit may be

very great and may extend beyond the immediate circumference of the urethra, and involve the spongy portion of the penis, giving rise to those intractable nodular strictures we sometimes meet with. Here is a negro patient, in whom the condition is present to a most marked degree. He has frequently contracted gonorrhœa, and is now suffering from severe symptoms of stricture. When I raise up the body of the penis and feel the spongy portion, I find that it is the seat of an enormous induration or callosity, which will demand for its relief a very extensive internal urethrotomy.

To sum up these very brief remarks on the pathology of stricture, I may state that stricture may occur in any part of the urethra, with the exception probably of the prostatic portion. It may vary in degree from the slightest narrowing, elastic or yielding to the presence of the instrument, up to the almost impassable barrier we observe in this negro's case. It may be single or multiple; five, six, seven, or more narrowings being found in the same urethra. It may be elastic or resilient or resisting. It may be exquisitely sensitive, and intolerant of the slightest manipulative attack, or it may be callous, and apparently insensible. It may bleed upon the slightest touch, or it may, on the other hand, be handled with impunity.

In practice the great question, gentlemen, for you to decide is the clinical one of treatment. You have seen how protean is the nature of stricture, and you have, at the hands of my colleagues and myself, witnessed the varying curative procedures we have resorted to.

When a man suffers from stricture and determines upon seeking professional advice, he generally does so under one or other of the following train of circumstances. In the first place, his condition may not be very urgent, he is simply inconvenienced; or, in the second place, it may be urgent; urination may have become difficult, or possibly even retention may be imminent, or may have occurred. Let us take the former case, in which the symptoms are not very urgent or aggravated. The man will tell you he has had a slight stricture for months or years.

Some or all of the usual symptoms of obstruction may be present, but to a slight degree. He has become used to them; they scarcely trouble him, or if they do, it is by their continuance, rather than by their severity. Or he may say that urination is not much more frequent than usual, that he voids his water tolerably well, but that when he is about to pass it, he is conscious of a delay or hesitancy in the appearance of the flow. He is therefore obliged to strain a little more than usual, and his urination is slightly prolonged. In any event, he is somewhat alarmed, he feels a little nervous as to his future, and wishes to be cured. So, from one cause or other, he presents himself at your office for examination.

And here I must beg you to bear in mind that this matter of examination is one of the first importance, and deserves to be fairly studied. Of course the merest tyro can form an idea of the presence of a stricture, but this is not all that is required. The surgeon by his manipulation should learn, not only the site of the obstruction, but also all that it is possible to find out concerning its character. By this I mean its sensitiveness or irritability, its shape, direction, and the tortuosity of the urethral canal at the contracted point. The distance of the stricture from the meatus should also be carefully measured and, if possible, the existence and localities of other points of narrowing, should these be present. Now all of these matters it is important to know, not only in the interests of diagnosis, but also in order to arrive at a just decision as to the treatment proper to each individual case.

I insist, therefore, upon a careful examination, such as may result in developing the true condition of affairs. The proper treatment will then follow as a matter of course, for, as you may infer, the attack must vary with the defence, and the instrument which may be well suited to act upon an annular insensible stricture may be quite out of place if the stricture be tortuous or irritable, or both. In conducting urethral manipulations upon a patient you must see that he be placed in the proper position, and that you yourself are also properly placed. For my

own part, I never examine a man in the upright posture. I always make him lie down, either upon a sofa, or, which I greatly prefer, upon a table of sufficient height, not less than thirty or thirty-one inches from the floor. This is a good height, if the surgeon be of medium stature. If the table be lower than this, you will be obliged to bend over your patient. This, in itself, is fatiguing, and if unduly prolonged may interfere with the requisite delicacy and gentleness of touch. Depend upon it, if the surgeon be wearied or if he works at a disadvantage, the patient suffers. So take my advice, and place both your patient and yourself in just those relative positions which are most favorable for the work on hand. Of course, these remarks apply with increased force to those cases in which the highest and most delicate skill is demanded, and especially when these manipulations are prolonged, but I think they are not without bearing in the every-day applications of urethral instruments. The office table which I use for these examinations is of the height I have mentioned, and is provided with diverging slide rests for the feet, somewhat after the gynecological chairs so much in vogue. You here see just such a table, and you have often, I am sure, noticed how securely the patient rests, how firmly his limbs are supported, and how much easier it is for the surgeon to operate and the patient to endure under these circumstances.

Now, as to your own position. In the great majority of cases the patient rests at full length upon a lounge, or sofa, or table, with his feet drawn up, and his shoulders raised; you may stand upon either side, preferably, I think, upon the left, thus using the instrument with your right hand. For my own part, however, in all really difficult cases of stricture, and in obstinate obstruction dependent upon enlarged prostate, I greatly prefer to place my patient on the broad of his back, and to stand between his knees. In office practice, and with a table or reclining chair furnished with foot-rests, this can readily be done. At a patient's home, you will not have this convenience, but you can always bring the man to the

edge of a bed, letting his buttocks rest upon a pillow, and having his feet supported by two chairs and his knees well separated. A pillow or two should be placed under his head and shoulders, so as to elevate his trunk to a proper degree. Each thigh and leg should be wrapped in a separate blanket or shawl. If the patient have on his drawers, let him take out only one leg, say the left, and then only the other will require to be blanketed. The body should be well covered and proper care taken to protect the patient from draughts and currents of air. A patient who is warm, well-protected, and comparatively comfortable, retains his confidence longer, and will submit to a much more prolonged endeavour on the part of his surgeon than one who is chilled, trembling and nervous. In difficult operations, as, for example, in those for aggravated stricture, or for retention of urine, you will do well to take your stand between the patient's knees. By so doing you will be able to manage your instruments to the best advantage, and you will the more readily preserve in your mind the precise relations between the point of the instrument in your hand and its anatomical bearings. But, in ordinary cases, and in every-day practice, it will answer quite well to stand upon the patient's left side, as I have already explained to you.

Next, you will introduce an instrument to examine the urethra, and search for the suspected obstruction, and for this purpose you can employ either a metallic or flexible instrument. I do not think it matters very much which you make use of, provided the point be a rounded one; and not a conical one. As a rule, patients have a greater dread of the metallic than of the flexible instrument, and it is therefore perhaps well to use the flexible one at first. But in this matter of urethral exploration, professional opinion has of late years undergone much change. Formerly it was taught, by no less an authority even than Sir Henry Thompson, I think, that if an instrument, say a flexible one of the calibre of No. 10, English measure, passed easily into the bladder, that there could be no stricture. But

more recently the investigations and industry of our countryman, Dr. Otis, have shown that this is not altogether the case. Dr. Otis asserts that instruments of moderate calibre, as those I have mentioned, may pass quite readily into the bladder, and yet a stricture may be present. In other words, that the normal calibre of the urethra may at points be abnormally narrowed, and to such a degree as to check or impede the passage of the urine to a certain extent, and thus, in Dr. Otis's opinion, to develop many of the phenomena of stricture. To these narrowings the term "strictures of large calibre" has been applied, and without being prepared to go quite as far as Dr. Otis does in the matter of incision of these stricturing bands, we must all admit that a most valuable contribution has been made to the subject of urethral pathology. It is evident, too, that in the examination of urethrae suspected of stricture, in the future, we must look more closely than possibly we have hitherto done, and direct our operations accordingly.

I therefore advise you to be very careful in your investigations of the closed urethra. The flexible No. 10 or 12 catheter, well warmed and curved gently down, may be arrested say at two, three, or six inches from the meatus. The existence of an obstruction or stricture is most manifest; this you have learned, and it is an important fact in the history of the case. But you must learn more, you must find out exactly the distance of the stricture from the meatus, its length, and the presence of any lower or more deeply seated obstructions. For this purpose you will resort to the flexible olivary or acorn-ended bougies I show you here, and with which you are already so familiar from their frequent use in this arena. You know from observation how the exact site of one or more stricturing bands or rings may be detected, located, and measured.

Now, let me suppose that we have found and measured accurately a stricture, distant let us say five and a half inches from the meatus, and let us suppose also that this stricture will admit a small sized catheter, thirteen to seventeen

of the Charrière scale; that is, from about seven to ten of the English measure. The parts are not very sensitive, and the patient is in good condition. How shall we treat this man? We have three methods to our choice, dilatation in some gradual form; division, or rapid forcible dilatation; and incision from within the urethra, or internal urethrotomy as it is called. My answer at once is, by dilatation; failing in this then by internal urethrotomy.

Dilatation, as you are well aware, may be accomplished by one of two plans—it may be either slow or rapid. The former is effected by the daily and continuous use of sounds. Thompson's sounds made of steel, and nickel-plated, which I show you here, are the best—or the parts may be gently dilated by small instruments, flexible or metallic, up to a calibre which will admit the insertion of one or other of the gradual dilating instruments in use. The blades of the latter are then slowly but firmly separated by the screw in the handle, and the walls of the strictured urethra are thus efficiently stretched. This process may be repeated, if necessary, at an interval of a few days, although it is generally required to a very much less extent, and the cure of the stricture may then be completed by the introduction of sounds daily, semi-weekly, and really at longer periods. Before discharging a patient from treatment, I always instruct him in the passage of the sound, and I see that he can do so with certainty and confidence. I then direct him to pass the instrument every week or ten days. The dilating blades I prefer are on the table before you. You have witnessed their action time and again. Here is Thompson's, which will pass through a stricture of No. 11 Charrière's measurement; here is another form of the same instrument in which the blades separate perfectly parallel. Its character is the same as the preceding, and, in consequence of their small size, both of these instruments are eminently suitable for the stretching of tight strictures. I show you now another instrument of which I think most highly, it is the one devised by my colleague, Dr. S. W. Gross. It is larger than those I have first shown you, its diameter cor-

responding to No. 17 or 18 of the Charrière scale. It is a powerful instrument, and admirably adapted for the stretching of hard, tight strictures. It has moreover one great advantage, and that is a graduated scale in the handle, which tells you while you are turning the screw exactly to what extent the blades of the instrument are separating the strictured walls.

Here, then, gentlemen, you have excellent means for treating a stricture by dilatation, first by bougies, and next by the stretching instruments I have alluded to. Now if from any reason, say irritability of the stricture, excessive or prolonged pain, extreme nervousness on the patient's part forbidding repeated manipulations; or the presence of a stricture so elastic or resilient as always to return on the cessation of manipulation, dilatation fail, or prove unprofitable, what then must be done? In my judgment the time has now been reached at which internal incision, the operation of internal urethrotomy, is not only justified but is urgently called for. I prefer, usually, dilatation in some form to incision of this stricture, but when dilatation fails, incision is pre-eminently the operation. It matters little, I think, which variety of cutting instrument is selected. Here are three of them. Dr. Otis's, Dr. Gross's, and the Charrière combination of Civiale's and Maisonneuve's urethrotomes. The two former cut in a dilated urethra. The latter acts upon the urethra in a partially flaccid condition. You may take your choice. From long habit, I have become accustomed to the Charrière instrument, but you have all witnessed how beautifully the urethrotome of my colleague does its work. Let us suppose we have divided a stricture by internal urethrotomy; what is the after treatment? You have seen me over and over again prosecute it before you in this arena. The division once effected, and before the patient is removed from the table, I introduce the nickel-plated sound, until a sufficient calibre has been attained, let us say No. 27, 28, 29, or 30. I then direct a full dose of opium and quinia, have the man well covered up, put to bed, and do not touch him, or permit him to be touched with an instrument for three

or four days. Too much urethral meddling at this time is, I am satisfied, bad; it can do no good, and may do much harm. When the sick man shall have recovered from the shock of the operation, if shock there be, and this I think is more apt to take place when ether is used than when it is not, then I begin the use of my sounds, and instruct my patient in the same manoeuvre. If he be expert, he should now be able to preserve the patency of the urethra, and thus render himself the master of his own case in the future, at all events subject only to the occasional surveillance of his surgeon.

I have thus far, gentlemen, spoken to you of strictures which, when first brought before your attention, permit the passage of a small instrument, No. 9, 10, or upwards. Let us now examine those of a more severe character, such, for example, as were present in the men Durrell, Small, Connu, and others. The history of these patients and their brethren may be thus epitomized: First of all, years ago, a neglected gonorrhœa, followed by successive claps, aggravated by exposure, hard living, and possible debaucheries. With time the stricture or strictures gradually became tighter and tighter, the pain on micturition increased, and the whole train of urinary symptoms assumed an irritative character with which the constitution largely sympathized. On examining each man we found stricture of the most determined nature, so tight indeed as to forbid the entrance of all ordinary instruments. In old times, such strictures were called impermeable, impassable strictures; but, as has been justly observed, no stricture can be called impermeable, through which even a drop of water at times can pass. Impermeability is in fact but a relative term, and with the improved instruments at our hands does not exist. The stricture which a few years ago was so difficult to manage, has now become docile to a degree, and this has been brought about in great degree by the introduction of the whalebone filiform bougie and the tunneled catheter.

I do not intend here to enter into the vexed question as to the priority of invention of these, and especially of the latter

instruments. I am heartily thankful that we have them all, and to whomsoever their origin is due, we owe our hearty acknowledgments. I have already frequently drawn your attention to these whalebone bougies, and have endeavoured to impress upon you that if you would derive from them their greatest benefit, you must not rest content with such as you find in the shops, but must yourself dress them down as I have shown, until in tenuity they become really capillary in character. How well these answer their purpose, I am sure you know, and I hope that you are ready to agree with me when I say that if these whalebones be properly prepared, there is no stricture (excluding rupture of the urethra, and those of traumatic origin) through which they cannot be passed. Of course, as you already understand, this may not be done at once, and it is scarcely possible to effect it, if other instruments of large calibre have been recently used at the hands of other surgeons. I have already cautioned you in cases of very tight stricture always to begin your operations with these whalebones, and carefully to abstain from the use of large round or blunt-pointed instruments, which can only serve to batter down, as it were, the adjacent tongues or folds of mucous membrane upon the orifice of the stricture, and thus hiding it, cause it for the time to escape the search of the first instrument. Do not forget these matters, but bear always in mind two facts. First, that the whalebone bougies to be of service at all, must be very fine and flexible, not plate drawn, or made with the file, but shaven with a sharp knife, and truly capillary. In the second place, no other instruments on the same day should precede their use. These, as you have seen, succeed when properly inserted and in sufficient number, sooner or later one of your quiverful must strike the orifice of the stricture, and inevitably enter the bladder. The difficulty always is simply one of search. If urine can pass, an orifice undoubtedly exists, and the canal however strictured will always permit the passage of the hair-like whalebone. In treating badly strictured cases you should start with the firm conviction that you

must find the opening, and that the instrument must go in. Be patient, and persevering, and you will surely be successful, and be spared the ignoble plea of "spasm."

When once a whalebone bougie has been made to enter the bladder, the victory over the stricture is assured. You have but to pass these tunneled catheters until a calibre of urethra is attained sufficient to place the stricture at your mercy. But here a caution is necessary. The ordinary tunneled catheters, even of smallest size, as usually met with, are too large. You must see that yours of lowest number shall possess no greater calibre than just that which is necessary to slide readily downward along your filiform bougie, and to pass it through the stricture you must employ the proper manoeuvre. Thus, slide the instrument along the whalebone until the stricture be reached, and then the whalebone and catheter being grasped together, carry both forward through the stricture by the same motion of the hand. By these means, successive catheters may be passed into the bladder, gradually overcoming and distending the stricture, until the ordinary sounds, dilating instruments, or urethrotomes can be used with advantage.

You may notice, gentlemen, that I have thus far said nothing to you of division, or bursting, or the treatment by Mr. Holt's method. Some time since I practised this procedure extensively, as indeed did many of my surgical friends of this city. Admirably successful as it was in numerous cases, it was however in other instances attended by severe shock. Unfortunately I have had more than one opportunity of observing in post-mortem examination the effect of the instrument upon the urethral mucous membrane. As far as my experience goes, in every instance the mucous membrane, as well as the submucous callous bands, were divided as cleanly as if they had been cut by the blade of the urethrotome. I should, however, state that in all cases which I have known of death following the use of Holt's divulsor, the unfortunate result has occurred in public practice, among patients in the lowest social scale, whose constitu-

tions had been broken down by lives of vice, intemperance, exposure, and debauchery. I have never known a death to occur in private practice from the use of this instrument. I have, nevertheless, come to regard the methods by dilatation in its various forms, combined with internal urethrotomy when necessary, as the preferable modes of treating urethral stricture.

Retention of urine, more or less complete, is one of the gravest accompaniments of urethral stricture. During the last three or four weeks we have received in hospital six of these cases, and you have had the opportunity of witnessing the different treatments resorted to for their relief. In all of the cases the bladder was very full, in fact greatly over-distended; and the agony and distress of the poor sufferers were extreme. This you can readily understand when you consider for a moment how great must be the tension, when the bladder, which ought to hold a pint, or a pint and a half, is gradually and cruelly distended to the capacity of from fifty-five to sixty-five fluid ounces. So great is the stretching, that the muscular coat is entirely paralyzed; it cannot act, and no urine escapes, save the little dribble of overflow, which forces its way past the resisting stricture. You have seen these cases, and I therefore need not now dilate on their sufferings and perilous condition.

What, gentlemen, will you do when called upon to treat such patients hereafter? The warm bath, opiates, and anæsthetics are all very well in their way, excellent adjuncts to your treatment, but much more is required. You cannot turn your back on these cases, and postpone active treatment to a more convenient season. You must do what is necessary to effect their relief at once. And here let me say to you, that you must have confidence in yourselves; you must feel that you are able by some means or other to bring to the patient the relief he stands so sorely in need of. What, then, should your treatment be? First of all, it is well to have the sufferer placed in a warm bath, the heat of which is gradually increased by fresh additions of hot water.

Then, in ten or fifteen minutes, place the patient, if not relieved, upon the table, and have him thoroughly anesthetized. It may be that the circumstances of the case have not permitted a hot bath. You must then resort to the ether at once. When your patient shall have come fully under the influence of the ether, you will begin your attempt at catheterization. This may be usually effected by one of two methods—the use of the whalebone bougies, or the employment of large rounded instruments. I prefer to begin with the former always. It is in operating upon a case of retention that it is so important that the patient should be upon a high table, for then the surgeon can work without being fatigued, and these manipulations are often very prolonged. Sooner or later, if you be persistent and adroit, and work in the manner I have taken so much pains to demonstrate to you, you will succeed in inserting a filiform bougie into the bladder. You have seen me so succeed, when I know most of you have regarded the result as almost a hopeless one. But you can succeed, and you will succeed, if only you will make for yourselves such filiforms as I make and employ in the treatment of these cases. You must have patience, and not become discouraged and fly off to other procedures. Be pertinacious, and gentle, and in the end you will accomplish your purpose.

Let us suppose that you have at last passed a fine filiform through the stricture and into the bladder, what is your next endeavour? You may try and pass over it, in the manner I have taught you, a tunneled catheter of the smallest size. Possibly you may succeed; more probably you will fail at your first attempt. In that event I advise you not to continue your efforts in the same direction, but to withdraw the catheter from the urethra, taking care to leave the whalebone filiform in position, and being sure that its minute olivary end projects into the bladder. In a little while you will be rejoiced to find that the urine will pass freely by the side of the whalebone. Here I show you a basin full of urine tinged with blood, which has in this manner been voided

from the bladder in a case of very bad retention in this ward since yesterday afternoon; and at our last clinic I made you a similar exhibit. A warm bath now, and a full dose of opium, will accomplish all that can be desired, when once the instrument, no matter how fine, has been carried into the bladder.

You may, gentlemen, perhaps think that I am urgent to weariness on this topic, but the time may arrive when you will require all your professional resources in overcoming an obstinate retention, and I am assured that the procedure I have described to you will then be found very potent for good. At all events, it is the one upon which I mainly rely, and you will take it for what it may be worth, and judge of it by your own clinical experiences hereafter.

HOSPITAL NOTES AND GLEANINGS.

A Case of Antiseptic Ovariectomy in a Syphilitic Patient; Recovery; Remarks.—R. M—, aged forty-four years, stated that she had been married twenty-one years, and had given birth to five children, who had never manifested any signs of constitutional disease. She had never miscarried. Eight years before admission, subsequent to her last confinement, she had a severe attack of rheumatic fever, and twelve months before she noticed the enlargement of the abdomen. The swelling commenced on the right side. She positively stated that she was not aware that she had ever contracted any other disease.

On her admission into the Royal Portsmouth Hospital, under the care of Dr. J. WARD Cousins, she looked pale, careworn, and emaciated. On the forehead were four fistulous ulcers, discharging offensive pus, associated with extensive caries of the frontal bone. The surrounding skin for some distance was irritable, red, and tender. The voice was thick and husky, and there was chronic laryngeal irritation and cough. The abdomen was much enlarged; two inches below the umbilicus it measured thirty-three inches in circumference, and fourteen inches from the ensiform cartilage to the pubic symphy-

sis. Dulness was well defined, and fluctuation over the right half of the tumour was moderately distinct. During respiration the abdominal walls did not appear to move over the surface of the tumour. On vaginal examination the right side of the pelvic cavity was fuller and more elastic than the left, but no solid substance could be detected, and no fluctuation occurred on external percussion of the abdomen. The uterus was movable; its cavity measured three inches.

On June 4th, 1878, the tumour was tapped with the hope of relieving the dyspnoea and oppression which greatly distressed her, but only three pints and a half of thick brownish fluid, of the consistency of gruel, were withdrawn. Severe abdominal pain and fever for some days followed the operation.

Antiseptic ovariectomy was performed on July 2d. The tumour was multilocular, and weighed eleven pounds. Some extensive omental adhesions were separated, and the bleeding vessels were secured with fine silk ligatures. The pedicle was clamped externally. The day following the operation the temperature stood at 108° and the pulse at 130; but on the 6th all urgent symptoms had subsided; temperature 99°; pulse 90, fairly full, and regular. The wound rapidly healed, and the clamp came off on the tenth day. During her convalescence she suffered from two attacks of erythematous inflammation of the forehead and face, but these attacks, she stated, had frequently occurred during the last three years. The constitutional disturbance was only trifling, and scarcely impeded her recovery. She left the hospital on August 5th. In January, 1879, she was in better health than she had been for years, but the constitutional manifestations of syphilis were unchanged.

Remarks by Dr. COUSINS.—The interesting point in the case is especially associated with the constitutional condition of the patient at the time of the operation. She had undoubtedly contracted syphilis (probably since her last pregnancy), and she was labouring under tertiary complications. Her general condition was greatly damaged by the disorder, and the

deep character of the taint was manifested by the caries of the frontal bone and the chronic laryngeal mischief. To say the least, at the time of the operation the patient was the subject of a cachexy associated with the remote effects of syphilis, and a risk was present that the shock of a severe surgical proceeding might excite the old disorder into some form of dangerous activity. Her condition, however, appeared to be actually more favourable for interference than any future condition could possibly be. The constitutional powers were, indeed, seriously damaged, and the nutritive and reparative action of the system impaired; still, the immediate danger of her case arose more from the presence of the abdominal tumour than from the syphilitic complication. The result of the operation has given her a fair prospect of living several years, and has placed her in a better condition for struggling with a grave and tedious disease, which in the lapse of time may undergo a favourable modification.

The taint of syphilis, even of the tertiary stage, is not wholly confined to certain tissues and organs. It sends a latent influence throughout the entire organization. The patient looks aged, sallow, and emaciated; and the term "syphilitic cachexy" expresses the deep constitutional changes which have been stamped upon the vitality and nutrition of all the structures. It is an interesting fact that the presence of a specific cachexy does not always retard the healing of recent wounds. In this case the abdominal incision closed rapidly and firmly in a few days. In the peculiar cachexy, too, which attends the last stages of cancer the reparative power of a part may be roused by a wound into remarkable activity. Three years since a patient labouring under carcinoma of the uterus came under my care with strangulated femoral hernia. She was sallow and emaciated by long-standing disease, and had been confined to her bed for weeks with constant uterine hemorrhage. Herniotomy was performed; the wound healed by first intention, and the patient rallied, and lived nearly two years after the operation.—*Lancet*, April 5, 1875.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The Prevention of the Spread of Yellow Fever.—The National Board of Health recommends the adoption of the following rules and regulations for the prevention of the spread of yellow fever:—

All cars leaving infected places shall be thoroughly cleansed and fumigated with sulphurous acid gas, by burning eighteen ounces of sulphur for every 1000 cubic feet of space, closing up the car tight for six hours prior to date of leaving.

No upholstered car shall be allowed to leave a dangerously infected place.

All baggage shall be thoroughly disinfected at the station before leaving.

At a point not less than five miles, and as near this distance as possible, from the point of departure from a dangerously infected place, there shall be an entire transfer of passengers and baggage to other cars, which cars shall never enter an infected district.

This transfer shall be made in the open air under the supervision of a medical officer, and as far from a habitation as possible; and no person with fever shall be allowed to proceed, but shall return to the point of departure, or be treated in hospital at or near the place of transfer.

The medical officer at the transfer station shall carefully examine the conductor's certificates, and the certificate of each passenger, and fill the blanks appended to them to accord with the results of his examination.

No sleeping-car shall be allowed to leave a dangerously infected place, nor shall any sleeping-car approach nearer such place than the point of transfer. Any passenger car leaving such infected place shall be thoroughly ventilated during its passage to the place of transfer, by having the windows of the cars open during such passage.

In case of suspected infection of a passenger car, or of a sleeping-car, such car, including all the upholstery, cushions, curtains, mattresses, etc., shall be thoroughly disinfected, under the supervision of a medical officer, and shall be exposed

to the open air for at least twenty days before being again used.

All freight shall be transferred at a point not exceeding fifty miles from the point of departure, and the cars from which such freight has been transferred shall not proceed further on the road, but shall be returned to the point of departure. The freight cars, after unloading, shall be thoroughly cleansed by scrubbing, fumigation, disinfection, and ventilation.

Mail matter and mail bags should be heated to a temperature of two hundred and fifty degrees Fahrenheit, or should be otherwise disinfected before they are sent from infected places.

At some point not less than fifty miles from the first transfer station, a second complete transfer of passengers and baggage is desirable, and should be provided for by the authorities of the States through which the lines run.

If yellow fever infect a place situated upon a line of railroad, trains of all kinds may be permitted to pass through without stopping, and at a speed of not less than ten miles an hour, provided the National Board of Health has not declared it dangerous to do so, and published through the local health authorities a special rule forbidding it.

At a largely attended meeting of the representatives of the railroad and steamboat interests of the Mississippi valley, held at Memphis on the 2d of July, the above rules and regulations were read separately, discussed, and unanimously approved, and assurance was given of the cordial co-operation of the railroad and steamboat interests in all measures adopted by the National Board of Health in their efforts to prevent the spread of contagious and infectious diseases.

In a circular dated July 12, the National Board of Health recommends that whatever opinions may be held as to the causes of yellow fever and of the recent appearance of that disease in Tennessee and Mississippi, it is best to act as if it were a disease due to a specific particulate cause which is capable of growth and reproduction, transportable, and may be destroyed by exposure to a temperature above 240° Fahrenheit, or by chemical

disinfectants of sufficient strength if brought into immediate contact with it.

It is also prudent to assume that the growth and reproduction of this cause is connected with the presence of filth, in the sanitary sense of that word, including decaying organic matters and defective ventilation, as well as of high temperature.

The cases of yellow fever recently observed should be considered as due to causes surviving from last year's epidemic, and not to recent importation from other countries. It follows that there is a liability to the appearance of other cases in places visited by the epidemic of last year, and that there is danger of the spread of the disease to the North and the East.

The Board advises that all cities, towns, and villages be at once made clean, in a sanitary point of view. The first step toward securing this cleanliness is to obtain reliable information as to what parts of the place are clean, and what foul.

The results of a careful sanitary inspection of almost any city or town will show the existence of collections of decaying and offensive matters previously unknown, and which every one will admit should be promptly removed and destroyed.

Such inspections to be of value must be thorough and made by persons competent to recognize foul soils, waters, and air as well as the grosser and more palpable forms of nuisance.

They should also be made by persons who will report fully and frankly the results of their observations without reference to the wishes of persons or corporations. When the whereabouts and the extent of the evil are known the remedy is usually almost self-evident.

The National Board of Health will furnish, upon request, blank forms as a guide for such inspections.—*National Board of Health Bulletin*, June 28 and July 12, 1879.

New Hampshire State Medical Society.—The eighty-ninth annual meeting of this Society was held at Concord, June 17th and 18th, Dr. Alonzo F. Carr, of Goffa-

town, President, in the chair. The following officers were chosen for the ensuing year: President, Thomas J. W. Pray, M.D., of Dover; Vice-President, Granville P. Conn, M.D., of Concord; Secretary, Moses W. Russell, M.D., of Concord. The Society adjourned to meet on the third Tuesday in June, 1880.

Massachusetts Medical Society.—The annual meeting of this Society was held at Boston, June 10th and 11th, Dr. George H. Lyman, of Boston, President, in the chair. The following officers were elected for the ensuing year: President, Dr. Geo. H. Lyman, of Boston; Vice-President, Dr. David P. Smith, of Springfield; Secretary, Dr. F. W. Goss, of Roxbury. The next meeting will be held in Boston on the second Wednesday in June, 1880.

Rhode Island Medical Society held its sixty-seventh annual meeting at Providence, June 10th, Dr. Edward T. Caswell, presiding. The Trustees of the Fiske fund reported that they had awarded the premium of two hundred dollars for the best essay on the "Artificial Feeding of Infants" to Dr. Oliver C. Wiggin, of Providence, and the premium of two hundred dollars for the best essay on "Cholera Infantum" to Dr. Charles E. Banks, of Portland, Me. The following officers were elected for the ensuing year: President, Dr. E. T. Caswell, of Providence; Vice-Presidents, Drs. George P. Baker, of Providence, and Charles O'Leary, of Providence; Secretary, Dr. W. E. Anthony, of Providence.

Medical Association of the State of Missouri.—The eighteenth annual meeting of this Society was held at Columbia, Boone Co., May 20th and 21st, under the presidency of Dr. Schaffner, of Kansas City. The following office bearers were elected for the ensuing year: President, Dr. G. M. B. Maughs, of St. Louis; Vice-Presidents, Drs. A. W. McAllister, of Columbia, C. Lester Hall, of Marshall, W. H. Bryant, of Savannah, C. A. Thompson, of Jefferson City, and A. N. Girard, of Shelbyville; Secretary, Dr. A. J. Steele, of St. Louis. The next meeting will be held at

Carthage, on the third Tuesday in May, 1880.

Ohio State Medical Society.—The thirty-fourth annual session of this Society was held at Dayton, June 3d, under the presidency of Dr. B. B. Leonard. The following officers were elected for the ensuing year: President, Dr. J. A. Murphy, of Cincinnati; Vice-Presidents, Drs. John Davis, of Dayton, Thomas McEbright, of Akron, J. D. Edwards, of Xenia, and C. A. Kirkley, of Toledo; Secretary, Dr. J. F. Baldwin, of Columbus. The next meeting will be held at Cleveland, on the first Tuesday in June, 1880.

Michigan State Medical Society held its fourteenth annual meeting at Detroit, June 11th and 12th, Dr. Edward Cox, of Battle Creek, President, in the chair. The following officers were elected for the ensuing year: President, Dr. George K. Johnson, of Grand Rapids; Vice-Presidents, Drs. J. T. Thomas, of Battle City; D. O. Farrand, of Detroit; W. F. Breakey, of Ann Arbor; E. S. Snow, of Dearborn. The Society adjourned to meet in Grand Rapids on the second Wednesday of May, 1880.

Colorado Medical Association convened at Colorado Springs in ninth annual session, May 20th, 1879, Dr. A. Stedman, of Denver, presiding. The election for officers for the ensuing year resulted as follows: President, Dr. B. P. Anderson, of Colorado Springs; Vice-Presidents, Drs. H. A. Lemen, of Denver, M. Beshoar, of Trinidad, and E. W. Cushing, of Trinidad; Secretary, C. C. Lathrop, of Denver. The next meeting will be held at Denver.

American Neurological Association.—The fifth annual meeting of this Society was held at New York, June 18th, 19th, and 20th, Dr. F. T. Miles, of Baltimore, President, in the chair. A number of valuable papers were read, and the following officers were elected for the ensuing year: President, F. T. Miles, M.D., of Baltimore; Vice-President, R. T. Edes, M.D., of Boston; Secretary, E. C. Seguin, M.D., of New York. The Association adjourned

to meet in New York on the third Wednesday in June, 1880.

FOREIGN INTELLIGENCE.

Winckel's Disease.—At the Congress of Children's Doctors recently held in Berlin, Professor Winckel, the Director of the Royal Lying-in Institution of Dresden, communicated some observations which he had made upon an apparently novel children's disease occurring in that institution. An epidemic of it broke out towards the end of March last. Of twenty-three children attacked, nineteen, or 82 per cent. died, and the average duration of illness in the fatal cases was thirty-two hours. The illness began with a sudden stupefaction of the patients; the respiration became hoarse, accompanied with groaning, and occasional foaming at the mouth. One remarkable feature was a change in the blood. Dr. Winckel made incisions in some cases, but it was only by using pressure that blood could be extracted. It was then found to resemble a thick brown-black fluid of the consistency of a syrup. The body became flaccid, the liver much swollen; eventually convulsions supervened, during one of which the child expired. The President of the Congress, Privy Councillor Dr. Gerhardt, of Würzburg, suggested that this new disorder should be designated "Winckel's disease."—*Med. Times and Gazette*, May 17, 1879.

Dressmakers' Fingers.—The *Journal d'Hygiène* draws attention to a deformity, occurring in tailors and dressmakers, which has not yet been described. It is a contraction and ankylosis of the two upper phalanges of the fourth and fifth fingers of the right hand. This deformity is due to the position of the hand in sewing, when the first three fingers of the right hand are always active, while the other two are doubled up in the hollow of the hand, where they remain immovable. After a certain time, the tendons and flexors begin to contract, and adhesions and ankylosis are soon formed. The author advises prophylactic treatment: the hand must be extended on a board

during the night, and the patient be made to use all the fingers in gymnastic movements, and in working in the house and garden.—*British Med. Journal*, April 26, 1879.

Eczematous Eruptions of Stumps.—M. DUPLAY (*Gaz. des Hôp.*, June 28th) observed, at the Société de Chirurgie, that he had met with a condition of the stump after amputation, in two of his patients, which has not been noticed by authors. In both there appeared on the stump successive crops of eruptions of eczema, presenting all the characteristics and mode of evolution of ordinary eczema. During six months the eruptions resisted all modes of treatment, and disappeared at last by the sole power of nature. Neither of these patients had suffered from eczema before. M. Duplay believes that the eruption in these cases is analogous to those obstinate eruptions which occur on ill-nourished limbs, due to a trophic cause. He thinks that there is neuritis of the extremities of the nerves of the stumps, which is the point of departure of these successive crops of eruption. The eruption is of no consequence in itself, but it delays the wearing of an artificial limb for some months.—*Med. Times and Gazette*, July 6, 1879.

The Statistics of Whooping-cough.—Some very interesting details concerning the occurrence, etc., of whooping-cough were communicated by UNKUH at the Naturforscherversammlung in Dresden. In the outdoor department of the Hospital for Children in Dresden, 1952 cases of whooping-cough came under treatment during forty-three years. The majority of these cases occurred in the third quarter of the year, and especially in August; the minority in the second, in May. A greater predisposition to this affection seems to exist in female children than in male. The greater number of cases received were between the ages of one and four; the tendency to the affection seeming to increase with the years, thus out of 1000 infants in their first year, 35 were attacked with whooping-cough, and out of 1000 children who had reached

their fourth year, 99 had whooping-cough. The affection seldom occurred twice in the same individual, but abortive forms were often met with; these, however, were mostly confined to older children, who may or may not have had the cough. One hundred and thirty children died of whooping-cough, which was equal to 6.6 per cent., or 4.3 per cent. of the general mortality. Of those who had died, 67 (52 per cent.) were in their first year.—*British Med. Journal*, June 7, 1879.

Strange Course of a Bullet.—*The Presse Méd. Belge* (June 22) exhibits the following account of a case reported by Dr. AGUILAR in the *Annales de la Asociación Médico Argentina*: A young man received a ball from a revolver applied close to his chest, which entered it opposite the seventh rib on the right side, and ten centimetres from the median line. Hepatoperitonitis immediately followed, which was cured by leeching and mercurials. The state of the wound continued satisfactory, but the patient complained of very severe pain in the lumbar region, while the discharge of urine, which was at first bloody and then purulent, revealed the existence of a renal lesion. Some time afterwards the urine became clear, and the lumbar pains disappeared. Still, it could not be determined where the ball had lodged, when one day the patient was seized with complete obstruction to the passage of urine, and the catheter came in contact with the ball in the urethra. It was extracted by means of a forceps, measured seven millimetres in diameter, and was covered with incrustations. The ball had, during ten months, pursued its course through the economy, coming in contact with important viscera like the liver and kidney, distending the corresponding ureter, descending into the bladder, and entering the urethra.—*Med. Times and Gazette*, July 5, 1877.

The Diphtheritic Poison.—A singular instance of the vitality of the poison of diphtheria is reported in the *Vratchebnyia Vedomosti*. A gentleman in the south of Russia had, four years ago, lost a boy from diphtheria. A family vault

having recently been constructed, the coffin of the boy was transferred thither. Before it was lowered down into the vault, the father wished to look at the body, having entertained a suspicion that the child had been buried alive. An opening was accordingly made in the lid of the coffin, the whole family, including five children, looking on. The next day all the children were ill with diphtheria, and one of them has since died.—*British Med. Journal*, June 7, 1879.

M. Koeberlé's Ovariectomies.—M. KOEBERLÉ (*Gaz. des Hôp.*, June 21) communicated to the Strasburg Medical Society the statistics of his recent ovariectomies. In 1878 he practised seventeen with only one fatal result. Besides these he had four other gastrotomies, viz., extirpation of a fibro-cystic tumour from the broad ligament, two extirpations of fibrous tumours of the uterus, and an exploratory incision in a case of hæmatocele followed by chronic peritonitis, the hæmatocele recurring six months afterwards, and being again treated successfully by exploratory puncture. Of these four cases only one proved fatal. During the last four years M. Koeberlé has practised 100 ovariectomies with eighty-nine recoveries and eleven deaths. He ascribes some influence on the results to his practice of cleansing the peritoneal cavity with carbolic water.—*Med. Times and Gazette*, July 5, 1879.

Poisoning by Carbolic Acid.—A case of acute poisoning with carbolic acid through an enema is recorded by Dr. PRAETORIUS in the *Berliner Klinische Wochenschrift*, April 14th, 1879. The patient, a delicate lady aged 45, had been suffering for several weeks from an obstinate attack of diarrhoea, which could not be stopped by the usual agents, and threatened to undermine the patient's strength. The author prescribed an enema of a one per cent. solution of carbolic acid, of which a quarter of a litre was mixed with one-third of a litre of warm water. Hardly had one-third of this enema been injected, when the patient began to complain of

ness, and collapsed. The enema was of course immediately suspended, and the patient told to void her bowels. This was done; but she remained in a collapsed state till the bowels had been washed out with warm water, when she gradually recovered; but it was not till two hours later that the disagreeable symptoms disappeared. The diarrhoea, however, had been stopped by the carbolic acid.—*British Med. Journal*, May 17, 1879.

Death from Chloroform.—A death from chloroform recently occurred at Toronto. The patient had received an injury resulting in dislocation of the ankle-joint, accompanied with fracture of the lower end of the tibia. Chloroform was administered to facilitate reduction, and while the attendants were in the act of adjusting the parts, stertorous breathing was observed, and almost immediately afterwards respiration entirely ceased, and could not be restored. No organic lesion was discoverable at the post-mortem to account for the sudden death.—*Canada Lancet*, June, 1879.

A New Elastic Suture.—The following elastic suture is recommended by Dr. VOGEL for closing a gaping superficial wound, and for drawing the edges of the latter together. Wide strips of sticking-plaster are placed on both sides of the wound, from one to two inches from the edge. Several small holes are then made in that portion of the strips which is near the edge of the wound, and small-sized studs are placed into the openings. A narrow India-rubber band is then laid across the neck of two opposite studs, slightly tightened, and fastened. This new suture is said to have answered very well in cases where the metallic suture either caused suppuration or could not be applied because the edges of the wound were too far distant.—*British Med. Journ.*, June 21, 1879.

Suspended Animation.—The nitrite of amyl being a powerful agent in quickening the heart-beat, a few drops of this drug have a powerful influence in restoring the functions of the heart in cases of

drowning, hanging, or fainting. It is suggested, therefore, that it should always be used whenever attempts are being made to restore to life an individual apparently dead, or when it is desirable to settle the question whether a person is really dead or not. The dreadful thought of being buried alive has haunted the human race since its earliest days, and the discovery of some means by which this risk could be, if not evaded, at least greatly diminished, would prove an ineffable boon to mankind. Dr. T. Lauder Brunton, to whom we have referred this suggestion, considers it to be a good one. He adds that in ascertaining death the nitrite of amyl might be used along with the cord-test, of tying a cord round the finger. If the circulation have entirely stopped, the part beyond the ligature never becomes any thicker; but if the circulation continue, however slowly, the finger-tip beyond the ligature will sooner or later begin to swell.—*British Med. Journal*, June 7, 1869.

A New Method for Cupping Extempore.—The following practical advice is published in the number for December, 1878, of *Il Morgagni*. Take a piece of common paper of the size of the opening of the cupping glass and dip it into warm water before applying it. The paper being damp, the skin is kept cool, and prevents by the evaporation of the water the too extensive spreading of the vacuum. If the same piece of paper be used twice, it must be dipped in water before the second application. As far as the cupping-glasses are concerned, a large number of household articles which can be had everywhere, such as tumblers, jam-pots, etc., may take their place if the paper be applied to them in the way we have described. Half-a-dozen similar recipients, which are from three to five inches deep and wide, if applied at once, and the vacuum renewed every two or three minutes, will in about a quarter of an hour produce a most prodigious effect.—*London Med. Record*, May 15, 1879.

The Electric Light.—Prof. COHN, of Breslau, has been lately making experi-

ments with the electric light on the eyes of a number of persons for the purpose of testing its influence on visual perception and the sensation of colour. He has found that letters, spots, and colours, are perceived at a much greater distance through the medium of electric light than by day or gaslight. The sensation of yellow was increased sixtyfold compared to daylight; of red, sixfold; and of green and blue, about twofold. Eyes that could only with difficulty perceive and distinguish colours by daylight or gaslight were much aided by the electric light, and the visual perception was also much strengthened. Professor Cohn concludes from this fact that electric light would prove exceedingly useful in places where it is desirable that signals should be seen at a great distance. The engine used was Gramme's electro-magnetic apparatus, which rotates six hundred times in a minute.—*British Med. Journal*, May 17, 1879.

The Paris Faculty of Medicine.—M. Hayem has just been elected to the chair of Therapeutics, made vacant by the death of Professor Gubler.

OBITUARY RECORD.—At Paris, on the 29th of May, at the advanced age of 85 years, PIERRE ADOLPHE PIORRY, the distinguished author of *Traité de la Percussion Médiate*, to which was awarded, by the Academy of Sciences, the Prix Montyon in 1828. M. Piorry was for many years Physician to the Hôtel Dieu, and was appointed Clinical Professor in 1840. He was also officer of the Legion of Honour.

—At Paris, on the 7th of June, of angina pectoris, WILLIAM TILBURY FOX, M.D., aged 48 years. Dr. Fox is best known in this country by his excellent *Treatise on Skin Diseases*, which has passed through three editions, and at the time of his death he was engaged in revising the work for a fourth. He was an industrious writer, a good teacher and lecturer, and possessed one of the most lucrative office practices in London. He has been long regarded as one of the highest authorities on dermatology in Great Britain.

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